SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

Filing at a Glance

Company: Central United Life Insurance Company

Product Name: Application	SERFF Tr Num: CEUL-125964098	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 41221
Sub-TOI: H16G.002A Large Group Only - PPO	Co Tr Num: AP-MM-1008	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Robert Coleman	Disposition Date: 01/12/2009
	Date Submitted: 12/23/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Maj Med

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 01/12/2009

State Status Changed: 01/12/2009

Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Arkansas is our state of domicile.

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Deemer Date:

Filing Description:

Filing new application for previously approved Major Medical product.

Company and Contact

Filing Contact Information

Robert Coleman, Compliance Manager RColeman@manhattanlife.com

SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

10700 NW Freeway
Houston, TX 77092

(713) 821-6482 [Phone]
(713) 821-6551[FAX]

Filing Company Information

Central United Life Insurance Company
Wortham Tower
2727 Allen Parkway
Houston, TX 77019-2100
(713) 529-0045 ext. [Phone]

CoCode: 61883
Group Code:

Group Name:
FEIN Number: 42-0884060

State of Domicile: Arkansas
Company Type:

State ID Number:

SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	Other forms filed separately, $20 for each form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Central United Life Insurance Company	$20.00	12/23/2008	24699717

SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/12/2009	01/12/2009

SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

Disposition

Disposition Date: 01/12/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Application for Major Medical Insurance	Approved-Closed	Yes

SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

Form Schedule

Lead Form Number: AP-MM-1008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AP-MM-1008	Application/ Enrollment Form	Application for Major Medical Insurance	Initial		46	AP-MM-1008 12-11-08.pdf

APPLICATION FOR MAJOR MEDICAL INSURANCE COVERAGE (print clearly in blue or black ink)

CENTRAL UNITED LIFE INSURANCE COMPANY
10700 Northwest Freeway, Houston, Texas 77092

❑ **APPLY FOR NEW COVERAGE:**

❑ Applicant Only ❑ Applicant and Spouse ❑ Applicant and Children ❑ Applicant, Spouse, and Children

❑ Add Dependent ❑ Reinstatement Policy Number: _____

Section I: Plan Outline

Deductible: ❑ $1,000 ❑ $2,500 ❑ $5,000 ❑ SelectChoice (with Office Visit Copay) ❑ SaversChoice

In-Network Coverage: ❑ 80% to $5,000 ❑ 80% to $10,000 ❑ 50% to $10,000

Optional Riders: ❑ Prescription Drug Rider ❑ _____

Requested Effective Date: ____/____/____ Total Collected Premium and Fees $_____

Payment Frequency: ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

To be completed personally by the applicant, and spouse if applying for coverage.

1. Proposed Insured Information

Proposed Insured(s) (Print Last Name, First Name, MI)	Relationship	Full Time Student	Gender	Age	Date of Birth Mo.	Day	Year	State	Build Height	Weight	Social Security Number
1.	Applicant										- -
2.	Spouse										- -
3.	Child	❑									- -
4.	Child	❑									- -
5.	Child	❑									- -

2. Address _____
Number and Street or R.F.D. City State Zip

Phone: Hm: _____ Work: _____ E-mail Address: _____

3. Employment Data	Employed Full-Time?	Occupation	Avg. Monthly Earnings Last 12 Months
Applicant	❑ Yes ❑ No		$
Spouse	❑ Yes ❑ No		$

4. Are you the Custodial Parent for ALL Children to be insured? ❑ Yes ❑ No If no, state which child(ren) _____

5. Is any Proposed Insured or household member (including students away at school, whether or not now applying for coverage) currently pregnant? ❑ Yes ❑ No If "Yes", this coverage may not be provided. Whom/Relationship: _____

6. Has any Proposed Insured used any type of tobacco (including cigarettes, cigars, and/or smokeless tobacco) during the past 12 months? ❑ Yes ❑ No If "Yes": Whom/Details: _____

7. Are all Proposed Insureds U.S. Citizens? ❑ Yes ❑ No If "No", state whom and how long residing in U.S.A. Whom/Details: _____

Section II: Other Insurance

8. Other Insurance Information:

A. Are any Proposed Insureds covered by, or has application been made for, any type of medical insurance? ❑ Yes ❑ No

B. Is any Proposed Insured currently covered by Medicare or Medicaid? ❑ Yes ❑ No

C. Has any Proposed Insured been covered under a health insurance plan including COBRA within the last 18 months? ❑ Yes ❑ No

D. Is the insurance applied for intended to replace any existing insurance or insurance which has been terminated with any company? ❑ Yes ❑ No Proof of credible coverage attached? ❑ Yes ❑ No

E. Has any Proposed Insured applied for life, accident or health insurance or for reinstatement of such insurance, which was restricted, postponed, rescinded, cancelled, withdrawn or modified as to plan, amount, coverage or rate? ❑ Yes ❑ No Whom/Details: _____

Complete the following for each "Yes" answer to questions 8. A-D above and list all medical insurance applied for or now in force.

Proposed Insured	Name of Company/Policy No.	Plan Type (COBRA, Group or Individual)	Hospital Indemnity Only	Hospital		Major Medical		Effective Date	Termination Date
				Rm. & Brd.	Surgical	Deductible	Maximum		

SECTION III: MEDICAL HISTORY AND RELATED INFORMATION

9. In the last three years, has any Proposed Insured taken part in: skydiving, hang gliding, parachuting, bungy jumping, rock or mountain climbing, underwater diving, racing (any type); professional sports; piloting an aircraft, or rodeo events? ❑ Yes ❑ No If "Yes", circle activity and give details.) Whom/Details: _____

10. In the last five years, has any Proposed Insured had any arrests, a driver's license suspended, traffic violations or prior DWI/DUI/OUI's? ❑ Yes ❑ No (If "Yes", give details and provide Driver's License # and state of issue.) Whom/Details: _____

11. Has any Proposed Insured had prescription medication recommended or written but not filled or taken? ❑ Yes ❑ No Whom/Details: _____

12. Has any proposed insured or a dependent had complications of pregnancy, including, but not limited to cesarean section or miscarriage? ❑ Yes ❑ No Whom/Details: _____

13. Last Pap Smear(s): Date(s) _____ Result(s) _____ Follow Up(s) _____

14. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each Proposed Insured:

Proposed Insured	Condition, injury, symptoms, diagnosis	Onset Date Month/Year	Date of last treatment	Results/Degree of recovery	Name/Address of Attending Physician

For this insurance application to be considered and approved (or remain in force if applying for reinstatement), all questions must be answered knowledgeably, fully, and truthfully. This applies to all health consultation and treatment information, including routine physicals and well care. If any information on this application is intentionally misrepresented, any approval for coverage may be rescinded. Please provide details under Section IV entitled "Eligibility and Medical Details".

WITHIN ANY PROPOSED INSURED'S LIFETIME: Has any proposed insured EVER been medically diagnosed or had symptoms, treatment, or surgery consistent with ANY of the following: **Yes** **No**

15. Heart/Cardiovascular – high or low blood pressure, chest pain, congestive heart problems, heart attack, heart diagnostics, surgery, and follow up, mitral valve prolapse (heart murmur), irregular heart beat, pacemaker, congenital heart defects, rheumatic fever, or high cholesterol? . . . . . ❑ ❑

16. Circulatory – atherosclerosis (hardening arteries), varicose veins, phlebitis, carotid artery disorder, stroke, peripheral vascular disease, enlarged lymph nodes, blood clots, plaque, abdominal aortic aneurysm, venous stasis, or Deep Vein Thrombosis? . . . . . ❑ ❑

17. Digestive – colon and intestinal disorder (polyps, colitis, chronic diarrhea), esophagus, stomach, ulcers, hernia, gallbladder, pancreatitis, or ischemia? . . . . . ❑ ❑

18. Liver Disease – hepatitis (give type in the Medical Details section), cirrhosis, blood transfusion, cancer, abnormal liver studies, or transplantation? . . . . . ❑ ❑

19. Mental/Emotional/Behavior – alcohol abuse/addiction, drug use/abuse/addiction, depression/anxiety, chemical imbalance, bipolar, hyperactivity, Attention Deficit Disorder (ADD), mental deficiency/retardation, anorexia, bulimia, counseling, therapy, support groups, dissociative disorder, or insomnia? . . . . . ❑ ❑

20. Brain/Nervous – convulsions, tremors, fainting, headaches, dizziness, paralysis, neuropathy, concussion, any loss of consciousness, atrophy, Alzheimer's, cancer, degenerative nerve, encephalitis, or epilepsy? . . . . . ❑ ❑

21. Lungs/Respiratory – asthma, bronchitis, pneumonia, emphysema, obstructive respiratory disorders, diagnosed or exposure to tuberculosis, chemical or asbestos exposure, shortness of breath, apnea/sleep disorder, respiratory equipment, fibrosis, or respiratory failure? . . . . . ❑ ❑

22. Cancer/Tumors – cancer of any medical system, tumors/cysts (malignant or benign), leukemia, Hodgkin's disease, melanoma, including skin cancer, breast, testes, ovarian, bone, lung, pancreatic, brain, prostate, stomach, radiation therapy, chemotherapy, or reconstruction? . . . . . ❑ ❑

23. Breast Disease/Disorder – any changes, lumps, hardening, scar tissue, biopsies, breast implants, or fibrocystic breast? . . . . . ❑ ❑

24. Male/Female Reproductive – kidney/bladder, uterus/tubes/ ovaries, prostate, kidney or bladder stones, incontinence, infertility, endometriosis, genital warts, herpes, or sexually transmitted disease? . . . . . ❑ ❑

25. Musculoskeletal – arthritis (give type, joints affected in the Medical Details section), gout, polio, congenital disorder, back/neck spine injury, treatments, therapies, or adjustments, muscular dystrophy, multiple sclerosis, myositis, fracture, bone repair, joint replacement, cartilage injury or wear, or amputation? . . . . . ❑ ❑

SECTION III: MEDICAL HISTORY AND RELATED INFORMATION (Continued)

	Yes	No
26. Endocrine/Metabolic – diabetes, lupus, abnormal glucose levels, hypothroidism, hyperthyroidism, abnormal pituitary, adrenal glands, pancreatitis, goiter, Addison's disease, growth disorder, anemia, chronic fatigue, or weight change of greater than 10 pounds in the past year?	❑	❑
27. Eye/Ear/Nose/Throat – impairment of sight, hearing, or speech, surgery (disease or elective surgery), cataracts, deafness, macular degeneration, glaucoma, retinal tearing, blindness, tonsillitis, dizziness, vertigo, or acid reflux?	❑	❑
28. Immune System – Tested positive for Human Immunodeficency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or related conditions or symptoms?	❑	❑
29. Any other mental or physical impairment, disease or deformity, or symptom either undiagnosed or under consultation, advised testing, or treatments not indicated elsewhere in this application?	❑	❑

SECTION IV: ELIGIBILITY AND MEDICAL DETAILS - complete disclosure is required (An additional piece of paper may be attached if necessary)

Question Number: ________ ❑ Applicant ❑ Spouse ❑ Dep 01 ❑ Dep 02 ❑ Dep 03 ❑ Dep 04

Hospital Date(s), Reasons, Procedure ________

Diagnosis: ________ Prescribed or Possible Surgeries: ________

Medical Treatment: ________

Prescriptions, Date, Dosage, Frequency: ________

Physician Information: ________

Question Number: ________ ❑ Applicant ❑ Spouse ❑ Dep 01 ❑ Dep 02 ❑ Dep 03 ❑ Dep 04

Hospital Date(s), Reasons, Procedure ________

Diagnosis: ________ Prescribed or Possible Surgeries: ________

Medical Treatment: ________

Prescriptions, Date, Dosage, Frequency: ________

Physician Information: ________

Question Number: ________ ❑ Applicant ❑ Spouse ❑ Dep 01 ❑ Dep 02 ❑ Dep 03 ❑ Dep 04

Hospital Date(s), Reasons, Procedure ________

Diagnosis: ________ Prescribed or Possible Surgeries: ________

Medical Treatment: ________

Prescriptions, Date, Dosage, Frequency: ________

Physician Information: ________

SECTION V: AGENT INFORMATION AND CERTIFICATION

- Are you aware of any information not disclosed on this application relating to the health, habits or reputation of proposed insured listed on this application which might have a bearing on the risk? ❑ Yes ❑ No
- Did you see the applicant (also the spouse and non-minor dependents, if applying) at the time this application was executed? ❑ Yes ❑ No

  If No, Explanation. ________

  ____
- Was the monthly checking account deduction authorization completed (only if applicable)? ❑ Yes ❑ No

Mail Certificate To: ❑ Agent ❑ Applicant

Breakdown of Estimated Costs:

- Association Dues $ ________
- Total Medical Premium $ ________
- Total Other Premium $ ________
- Application Fee (Non-Refundable) $ 50.00
- Total Funds $ ________

Was a conditional payment made? ❑ Yes ❑ No $________

____
Agent Signature

____
Agent Name

____
Agent Number

____
Date of Signature

SECTION VI: DECLARATIONS, AGREEMENTS, AND SIGNATURES

I represent to the best of my knowledge and belief, that all statements and answers on this application are complete and true, and that I have read or had read to me the completed application. The application and any amendments will form part of the contract. I also understand and agree with the following:

1. Any insurance, if approved by Central United Life Insurance Company, will be in force only when issued in writing by Central United Life Insurance Company. The applicant must be a member of the association. Association dues and benefit premiums must be paid. Coverage will become effective on the later of: (A) the date of the application; or (B) the requested effective date; or (C) the 1st of the month following approval; or (D) the 15th of the month following approval. **2.** A change in the health of the proposed insured(s) after the completion of the application form and before the delivery of the contract may affect my eligibility for insurance with Central United Life Insurance Company. The completed application is the basis upon which Central United Life Insurance Company will decide to insure persons proposed for coverage. **3.** The agent does not have the authority on behalf of Central United Life Insurance Company to accept the risks, or to make, alter, or amend the coverage or to extend the time for making any payment due on such coverage. **4.** Any fraudulent statement or material misrepresentation on the application and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract. **5.** Medical benefits for pre-existing conditions may be limited.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, it's reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I agree that a photographic copy or a facsimile of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. This information may also be disclosed to any medical records company engaged by Central United Life Insurance Company, including, but not limited to MIB, Inc. and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Central United Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable Central United Life Insurance Company to make eligibility, enrollment, benefit determinations, and underwriting and risk rating determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Central United Life Insurance Company may refuse to consider my application for enrollment.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

Applicant Signature or ❑ Parent / Legal Guardian	Date Today
Spouse (if requesting coverage)	Date Today
Dependent (any competent adult on application over 18)	Date Today
Dependent (any competent adult on application over 18)	Date Today

Your application cannot be activated without the scheduling and completion of your personal profile interview.

NOTICE OF INFORMATION PRACTICES INCLUDING FAIR CREDIT REPORTING ACT NOTICE AND MIB, INC. NOTICE

CENTRAL UNITED LIFE INSURANCE COMPANY
10700 NORTHWEST FREEWAY, HOUSTON, TEXAS 77092

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living (except sexual orientation) as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the above address. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office.

MIB, INC. NOTICE

While the information regarding your insurability is treated as confidential, Central United Life Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, The MIB, upon request from that member company, will supply the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642 for hearing impaired). If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CEUL-125964098*	*State:*	*Arkansas*
Filing Company:	*Central United Life Insurance Company*	*State Tracking Number:*	*41221*
Company Tracking Number:	*AP-MM-1008*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*Application*		
Project Name/Number:	*Maj Med/*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Certification/Notice	Approved-Closed	01/12/2009

Comments:

Attachments:

AR1.pdf
AR2.pdf
Flesch score CUL.pdf
ARINS.pdf

		Review Status:	
Bypassed -Name:	Application	Approved-Closed	01/12/2009
Bypass Reason:	Filing application only. New application is under Forms Schedule tab.		

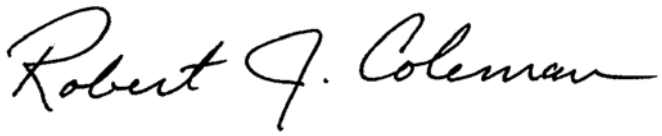
Comments:

ARKANSAS CERTIFICATION

Company Name Central United Life Insurance Company

Forms: AP-MM-1008

I hereby certify that Central United Life Insurance Company provides a Consumer Information Notice and Guaranty Fund Notice to each applicant in compliance with Ark. Code Ann 23-79-138 and Regulation 49.



Signature

Robert J. Coleman
Name (Typed or printed)

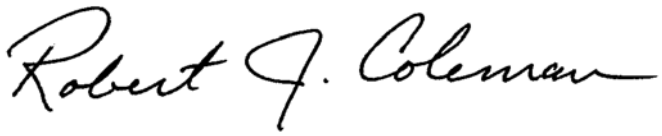
Compliance Manager

ARKANSAS CERTIFICATION

Company Name Central United Life Insurance Company

Form(s): AP-MM-1008

This submission meets the provisions of Rule and Regulation 19, “Unfair sex discrimination in the sale of insurance” as well as all applicable requirements of this Department.



Robert J. Coleman, Compliance Manager
Name and Title

December 23, 2008
Date

C E N T R A L U N I T E D L I F E

CERTIFICATION

I, Mary Lou Rainey, Secretary for Central United Life Insurance Company, hereby certify that the following form(s) has the following readability score as calculated by the Flesch Reading Ease Test set forth by your state, and meets the minimum reading ease requirements set forth by the state of Arkansas.

FORM	Readability Score
AP-MM-1006	46

DATE: December 23, 2008

Mary Lou Rainey

Mary Lou Rainey, Secretary

Central United Life Insurance Company
10700 Northwest Freeway
Houston, Texas 77092

Phone: 713-529-0045
Toll Free: 800-669-9030
Fax: 713-821-6551

MANHATTAN INSURANCE GROUP

CENTRAL UNITED LIFE

Central United Life Insurance Company
10700 Northwest Freeway
Houston, Texas 77092

Phone: 713-529-0045
Toll Free: 800-669-9030
Fax: 713-821-6551

MANHATTAN
INSURANCE GROUP

CENTRAL UNITED LIFE INSURANCE COMPANY

10700 Northwest Freeway
Houston, Texas 77092
(713) 529-0045
(800) 669-9030

Thank you for your excellent selection of insurance coverage. If you should have any questions or problems regarding your policy, please contact our Policyholder Service Department at the following address and telephone number:

Policyholder Service Department
Central United Life Insurance Company
10700 Northwest Freeway
Houston, Texas 77092
(800) 669-9030

or you can contact your agent at the following address and telephone number:

Name of Agent: _____

Agent Number: _____

Address: _____

Telephone #: (___) _____

If we at Central United Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Department of Insurance:

Arkansas Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-1904

Consumer toll-free telephone number:
(800) 852-5494